Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Wednesday, November 20, 2013 at the hour of 8:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Collens called the meeting to order.

Present: Chairman Lewis M. Collens and Directors Wayne M. Lerner, DPH, FACHE and Luis Muñoz, MD, MPH (3)

Director Ada Mary Gugenheim

Absent: None (0)

Additional attendees and/or presenters were:

Krishna Das, MD – System Director of Quality, Patient Safety, Regulatory and Accreditation
Randolph Johnston –System Associate General Counsel
Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief of Clinical Integration
Ozuru Ukoha, MD – John H. Stroger, Jr. Hospital of Cook County
Pierre Wakim, MD – Provident Hospital of Cook County
Joy Wykowski –Director of Intergovernmental Affairs

II. Public Speakers

Chairman Collens asked the Secretary to call upon the registered speakers.

The Secretary called upon the following public speaker:

1. Christine Zook Nurse Representative, National Nurses Organizing Committee

Following Ms. Zook's comments regarding the need for in-service training for registered nurses at the System, Chairman Collens indicated that this subject is at the top of the System's list of priorities, as it is very important. Director Lerner suggested that perhaps the Committee can receive a presentation on the subject from the System's Chief Nursing Officer in the future. He added that there are examples of online education available that are not instructor-dependent; it might be beneficial to take a look at that option. Dr. Ram Raju, Chief Executive Officer, concurred. He stated that the System's Chief Nursing Officer, Agnes Therady, recently joined the System. As is customary, senior staff presents to the Board on a regular basis, through the report from the Chief Executive Officer; he indicated that Ms. Therady can present her findings on the matter following her review[1].

III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation (Attachment #1)

A. Regulatory and Accreditation Updates
B. Physician Quality Reporting System (PQRS)
C. Publicly Reported Ratings

III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation (continued)

Dr. John Jay Shannon, Chief of Clinical Integration, stated that, at next month's meeting, a presentation will be given on Cermak Health Services[2]; additionally, he plans to provide a tentative schedule for all of the presentations for the upcoming twelve months[3], and will commit to providing the materials at least one week ahead of the meeting.

Dr. Krishna Das, System Director of Quality, Patient Safety, Regulatory and Accreditation, provided an overview of the information presented regarding regulatory and accreditation updates, the Physician Quality Reporting System, and publicly reported ratings. The Committee reviewed and discussed the information.

Dr. Das informed the Committee that representatives from the College of American Pathologists are reviewing the laboratory today at Provident Hospital.

Director Lerner inquired as to the role of the Board in site surveys. Dr. Das stated that having Board Members present at opening and closing conferences is extremely helpful; she added that the administration inquires whether the surveyors would like to talk to Board Members at the leadership sessions that are held with the surveyors, as well.

During the discussion of the information regarding PQRS, Chairman Collens inquired whether Dr. Das can report back to the Committee regarding the quality measures that will be chosen for reporting[4]. Dr. Das responded affirmatively. She stated that there is a menu of approximately fifty options; the administration is collecting ten for Meaningful Use.

During the review of the information regarding the Leapfrog Survey, the Committee discussed the subject of issues related to reporting individual patient events to the Board. Dr. Das stated that Leapfrog expects organizations to be explicit and inform their boards about these events; however, the Illinois Open Meetings Act (OMA) prevents this from being provided to the System Board in a closed session setting - no exception to the OMA currently exists that allows for the presentation of this patient-specific information to the Board in closed session. It was noted that, if there were an exception to the OMA that allowed this to be discussed in closed session, then the staff and Board can discuss the cases, but not reference names or other identifiers in that discussion. Dr. Raju stated that in most of the states in this country, boards can go into closed session to discuss in detail the individual patient events (not with patient identifiers). The State of Illinois does not allow this Board to go into closed session to discuss those events. Leapfrog wants the Board to receive information on the incidents, not receive only the overall statistics. He noted that one way that staff is trying to address the issue is by including a couple of Board Members on the medical staffs' quality committees, because information is presented on individual patient events at their meetings.

Following the review of information on Healthgrades, Dr. Raju provided additional comments. He stated that when the System's Medicare data is reviewed, the System does not do well because it has a very small Medicare population. Most of the System's patients are uninsured; that uninsured population's data does not go anywhere - no insurance company or even the State's Medicaid and Medicare programs monitor that. The other problem relates to documentation. Every hospital that does documentation well always receives better grades; additionally, documentation drives the coding. So if an institution has good documentation and very skillful coders, then they will receive much better ratings, because that captures the severity of the patients who come to the institution. This is another reason why documentation and coding are so important.

III. Report from System Director of Quality, Patient Safety, Regulatory and Accreditation (continued)

Director Lerner stated that, from a policy point of view, something that has been discussed at the American Hospital Association many times is that safety net hospitals are at a disadvantage because there is no database that truly compares the true nature of the patient population they serve.

IV. Action Items

A. Minutes of the Quality and Patient Safety Committee Meeting, October 9, 2013

Director Lerner, seconded by Director Muñoz, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of October 9, 2013. THE MOTION CARRIED UNANIMOUSLY.

B. **Medical Staff Appointments/Re-appointments/Changes** (Attachment #2)

Director Lerner, seconded by Director Muñoz, moved to approve the Medical Staff Appointments/Reappointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections IV, V and VI

V. Recommendations, Discussion/Information Items

A. Committee Education – Readmissions (Attachment #3)

Dr. Das and Joy Wykowski, Director of Intergovernmental Affairs, provided an overview of the information presented on readmissions. The Committee reviewed and discussed the information.

Dr. Das added that she will be presenting information on Value-Based Purchasing sometime in the future[5].

B. Reports from the Medical Staff Executive Committees

i. Provident Hospital of Cook County
ii. John H. Stroger, Jr. Hospital of Cook County

Dr. Pierre Wakim, President of the Executive Medical Staff (EMS) of Provident Hospital of Cook County, presented his report. He stated that medical leadership at Provident Hospital oversees and leads quality. At the meetings of the EMS, each chair or director of the units reports on their sentinel events and discuss any "near miss" cases. He stated that staff is currently working on the 2014 quality indicators for Provident Hospital for each department; after approval and discussion at the hospital level, it will be brought to the Committee and Board for approval and discussion.

V. Recommendations, Discussion/Information Items

B. Reports from the Medical Staff Executive Committees (continued)

Dr. Ozuru Ukoha, President of the EMS of John H. Stroger, Jr. Hospital of Cook County, presented his report. He stated that staff is laying down the infrastructure to provide the type of report on quality issues that has been requested by the Committee. He stated that, while the medical staff has been very much aware of the quality of care and patient safety matters, they have not been able to use data in a constructive way to actually generate reports that can be meaningful. He estimated that this may take a couple of months to build the infrastructure.

VI. Closed Session Items

A. **Medical Staff Appointments/Re-appointments/Changes

B. Litigation Matter(s)

The Committee did not recess the regular session and convene in closed session.

VII. Adjourn

As the agenda was exhausted, Chairman Collens declared that the meeting was ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
Lewis M. Collens, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

[1] Follow-up: findings from Chief Nursing Officer regarding in-service training for registered nurses at the System to be presented at future Board Meeting. Page 1.

[2] December QPS Meeting: presentation to be provided on Cermak Health Services. Page 2.

[3] December QPS Meeting: tentative schedule to be provided on presentations for upcoming 12 months. Page 2.

[4] Follow-up: PQRS - Dr. Das to report back to the Committee regarding the quality measures that will be chosen for reporting (future date). Page 2.

[5] Follow-up: presentation to be given on Value-Based Purchasing (future date). Page 3.

ATTACHMENT #1

Cook County Health and Hospitals System
Quality and Patient Safety Committee
Accreditation Update

November 20th, 2013

Krishna Das, MD

Chief Quality Officer

Commission on Cancer Accreditation:

- Cancer requires complex, expensive, multidisciplinary care
- A Cancer registry helps to coordinate and report cancer care data to regulators and drive institutional quality improvement

- 3-year cycle of accreditation by the Commission on Cancer: American College of Surgeons
- Reputational and funding implications
- July 16, 2013: one day site visit

Commission on Cancer

- Strengths
  - Nursing care – 25% have oncology certification
  - Cancer registrar education
  - Clinical trial accrual
- Deficiencies
  - Meeting schedule
  - Meeting attendance
  - Annual study of evidence based guidelines
  - Credentials of cancer registrars
  - Timeliness of data abstraction
  - Logistical issues with data submission (2 deficiencies)
- 3 year accreditation with contingency

Commission on Cancer

- Corrective actions
  - Meeting schedule and composition – corrected
  - Hiring and re-training of registrars – in process
  - Computer and logistical issues – corrected
- Future directions
  - Psychosocial assessment of cancer patients
  - Survivorship plans
  - Increase community involvement
  - Triage and enrollment of new patients

DEPT OF TRAUMA/BURN

BURN CENTER VERIFICATION

- Performed jointly by the American Burn Association and the American College of Surgeons
- Mark of distinction for High Quality Patient Care to the government, patients and 3rd party payors
- Repeated every 3 years and examines care from the time of injury to rehabilitation

DEPT OF TRAUMA/BURN

BURN CENTER VERIFICATION

- Infrastructure was deemed inadequate in 2004; verification was lost
- Requirements for a Burn step-down unit, PT/OT services, tissue bank
- 2013 inspectors congratulated CCHHS for corrections made
- Currently developing Morbidity and Mortality conferences with specific formats and loop closure X 6 months prior to final designation
- Attendings have all been trained in specific loop closure techniques requested by the examiners

Upcoming Joint Commission Surveys

- Ambulatory and Community Health Network Survey:
  - Window for survey through April 2013
  - Practically -- expected in next two months
  - Weekly preparation meetings and site visits
- Provident Hospital:
  - Window opens January 2014
  - Practically expected Summer 2014
  - Preparation underway

PQRS: Physician Quality Reporting System
Electronic Health Record Incentive Programs

PQRS

- Physician specific penalty/incentive program applied to Medicare Part B professional fees
- Incentives are based on each physician reporting quality measures to the Centers for Medicare & Medicaid Services
- Incentives are not dependent on achievement of specific quality targets

- Quality measures reported overlap with those reported through meaningful use

PQRS Incentives & Penalties

Category	Penalty (Incentive) on Part B professional fee	Baseline Measurement Period	Payment Adjustment Applied
PQRS 'Adjustment'			
	1.5% penalty if quality measures are not reported	2013	2015
	2% penalty if quality measures are not reported	2014	2016
PQRS Incentive			
	0.5% additional payment for reporting for each EP	2013, 2014	2015, 2016
Value Based Modifier			
	1% penalty for not reporting		Each year

PQRS Reporting at CCHHS

- Confirmed our intent to report with CMS
- Cerner will serve as our direct submission vendor
- Quality measures chosen based on our selections for meaningful use
- Data validation underway for specific measures
- Submission deadline 2/28/2014

Public Reporting and Ratings

Leapfrog Survey: Background

- Advisory group comprised of healthcare providers and consumers
- Proponents of hospital safety practices
- Annual survey of safe practices
- Nationally reported safety score
- 78% of Illinois urban hospitals have participated in the past
- Our current grade = C

Components of Hospital Safety Score

- Structural + Process Measures 50%
  - Computerized Provider Order Entry
  - Intensive Care Unit Staffing
  - Safety Practices
  - Surgical Care Improvement Project Measures
- Outcome Measures 50%
  - Hospital Acquired Conditions – retained object, air embolism, pressure ulcers, falls
  - Central Line-Associated Blood Stream Infections
  - Patient Safety Indicators – death in inpatients, iatrogenic pneumothorax, venous thromboembolism, accidental punctures and lacerations

Safety Practices

NQF Safe Practice	Details	Relative Weight
Leadership Structure	Raise awareness, establish safety program, PSO, engage leaders	120
Identify Risks, Hazards	Evaluate risk using RCA, FMEA, share with Board	120
Nursing Workforce	Evaluate safety events relative to nurse staffing	100
Teamwork Training	Define areas and processes to improve teamwork and team training	40
Medication Reconciliation	Evaluate safety impact of medication recon. & implement program	35
Hand Hygiene	Education and implementation	30
Culture Measure	Culture of safety survey, interventions	20
Prevent VAP	Implement standard processes	20

Safe Practice: Leadership Structures and Systems

AWARENESS	ACCOUNTABILITY	ABILITY	ACTION
•Board receives patient safety reports •Patient, family and community participation •Communication with staff regarding safety issues	•Patient safety program in place •Safety issues documented in performance reviews •RCAs communicated to management •Report sentinel events to external agency	•Safety budget adequate	•Regular •'walk- rounds' •Reporting patient safety meeting results to the board •All management actively engaged in safety efforts

Safe Practice: Identify, Mitigate Risks and Hazards

AWARENESS	ACCOUNTABILITY	ABILITY	ACTION
•Review all reports of adverse events (sentinel events, risk management, PSI, triggers tools) •Prospective risk evaluation (FMEA) •Share improvement plans across organization	•Risk assessment plan created	•Risk monitoring tools widely disseminated •Training provided and documented	•Establish a structure for identifying risks

Leapfrog: Next Directions

- Establish patient safety program and name PSO
- Establish methods for performing ongoing risk assessment
- Establish reporting of efforts to leadership and board
- Educate all staff in key issues in patient safety culture development

Healthgrades: Background

- Private company which ranks over 5000 hospitals
- Website with > 11M visitors annually
- Incorporates process and outcome measures
- Primarily utilizes claims data

- Uses a 1-3-5 star system for mortality and outcome measures

Healthgrades: conditions rated

healthgrades

Table 1. Healthgrades Mortality & Complication Rate-Based Procedures in 2014 Fall Release (2010-2012)

Mortality Rate-Based Conditions and Procedures by Specialty Area		
Cardiac Surgery • Coronary Artery Bypass Graft (CABG) Surgery • Valve Surgery *Coronary Intervention* • Coronary Interventional Procedures (Angioplasty, Stent) *Critical Care* • Pulmonary Embolism • Diabetic Emergencies • Sepsis • Respiratory Failure	*Gastrointestinal* • Bowel Obstruction • Colorectal Surgeries* • Esophageal/Stomach Surgeries* • Gastrointestinal Bleed • Small Intestine Surgeries* • Pancreatitis *Heart Attack* • Heart Attack	*Heart Failure* • Heart Failure *Neurosurgery* • Neurosurgery *Pulmonary* • Pneumonia • Chronic Obstructive Pulmonary Disease (COPD) *Stroke* • Stroke
Complication Rate-Based Procedures by Specialty Area		
Joint Replacement and Treatment • Hip Fracture Treatment • Hip Replacement • Total Knee Replacement *Prostate Surgeries* • Prostate Removal Surgery* • Transurethral Prostate Resection Surgery*	*Spine Surgery* • Back and Neck Surgery (without Spinal Fusion) • Spinal Fusion *Electrophysiology* • Pacemaker Procedures* • Defibrillator Procedures*	*Other Vascular Procedures* • Abdominal Aortic Aneurysm Repair • Peripheral Vascular Bypass • Carotid Surgery *Gastrointestinal* • Appendectomy** • Gallbladder Removal Surgery

*New cohorts introduced in 2014 Fall Release
**All Payer State Data

<u>Method:</u>

Outcome data is analyzed and each institution is ranked as follows:

1 * = below average

3 * = no different from average

5 * = above average

Sample Ratings: Stroger Hosp.

Diagnosis	Mortality (Actual)	Mortality (Predicted)	# Patients	Stars
Cardiac Interv	4.65	2.22	43	3
Heart Failure	0.35	2.54	288	5
Sepsis	32.5	17.6	40	1
Stroke	5.22	2.67	115	1
Colorectal Surg	0.0	2.68	60	3
Pneumonia	0.89	3.52	112	5

Healthgrades: Issues identified

- Small samples and coding issues affect data interpretation
- Coding for two diagnoses may be optimized
  - Sepsis
  - Stroke
- Better risk adjustment may improve rankings
  - Requires improvements in documentation and coding

ATTACHMENT #2

John H. Stroger, Jr. Hospital of Cook County

Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Dominguez, Virginia DDS Appointment Effective:	Surgery/Oral Health November 20, 2013 thru November 19, 2015	Active Dentist
Hathiwala,Suresh C., MD Appointment Effective:	Medicine/Nephrology November 20, 2013 thru November 19, 2015	Voluntary Physician
Jain, Ruchi, MD Appointment Effective:	Medicine/Rheumatology November 20, 2013 thru November 19, 2015	Consulting Physician
Stulberg, Deborah, MD Appointment Effective:	Family Medicine November 20, 2013 thru November 19, 2015	Voluntary Physician

Initial Non-Physician Appointment Applications

Barchfeld, Rebecca L., CRNA Effective:	Anesthesiology / Pain Mgmt. November 20, 2013 thru November 19, 2015	Nurse Anesthetist
Gates, Valeria, CNP With Emil F. Makar, MD Effective:	Medicine / Internal Medicine November 20, 2013 thru November 19, 2015	Nurse Practitioner
Schowalter, Karlene R., CNP With Anne J. Krantz, MD Effective:	Medicine / Occ. / Pulmonary November 20, 2013 thru November 19, 2015	Nurse Practitioner
Voll, Sarah T., CNP With Kelly, Russell F., MD Effective:	Medicine / Adult Cardiology November 20, 2013 thru November 19, 2015	Nurse Practitioner

REAPPOINTMENT APPLICATIONS

Department of Anesthesiology

Ghaly, Ramsis, MD Reappointment Effective:	Anesthesiology December 18, 2013 thru December 17, 2015	Active Physician
Nasr, Ned, MD Reappointment Effective:	Anesthesiology December 21, 2013 thru December 20, 2015	Active Physician

Department of Emergency Medicine

Ross, Christopher, MD Reappointment Effective:	Emergency Medicine December 16, 2013 thru December 15, 2015	Active Physician
Straus, Helen, MD Reappointment Effective:	Emergency Medicine December 16, 2013 thru December 15, 2015	Active Physician

Department of Family Medicine

Chin, Sophia Y., MD Reappointment Effective:	Family Medicine/ACHN December 16, 2013 thru December 15, 2015	Active Physician

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BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON NOVEMBER 20, 2013

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Medicine

Bodnar, Ulana R., MD Reappointment Effective:	Infectious Disease December 21, 2013 thru December 20, 2015	Voluntary Physician
Borkowsky, Shane, MD Reappointment Effective:	Hospital Medicine December 21, 2013 thru December 20, 2015	Active Physician
Brahmbhatt, Manish D., MD Reappointment Effective:	General Medicine November 20, 2013 thru November 19, 2014	Active Physician
Chataut, Chandra P., MD Reappointment Effective:	General Medicine December 21, 2013 thru December 20, 2015	Active Physician
Go, Benjamin T., MD Reappointment Effective:	Gastroenterology December 30, 2013 thru December 29, 2015	Active Physician
Mullane, Michael R., MD Reappointment Effective:	Hema/Oncology December 30, 2013 thru December 29, 2015	Active Physician
Pandey, Tanu S., MD Reappointment Effective:	General Medicine December 16, 2013 thru December 15, 2015	Active Physician
Rosen, Fred R., MD Reappointment Effective:	Hema/Oncology December 30, 2013 thru December 29, 1025	Active Physician
Tchernodrinski, Stefan T., MD Reappointment Effective:	Hospital Medicine December 18, 2013 thru December 17, 2015	Active Physician
Zimnowodzki, Simon, MD Reappointment Effective:	Neurology December 21, 2013 thru December 20, 2015	Consulting Physician

Department of Obstetrics and Gynecology

Yordan, Edgardo, MD Reappointment Effective:	Oncology December 21, 2013 thru December 20, 2015	Active Physician

Department of Pathology

Shi, Feinan, MD Reappointment Effective:	Pathology December 16, 2013 thru July 19, 2015	Affiliate Physician

Department of Pediatrics

Codispoti, Christopher D., MD Reappointment Effective:	Allergy/Immunology November 20, 2013 thru November 19, 2015	Voluntary Physician
Kagan, Tatyana, MD Reappointment Effective:	Emergency Medicine December 21, 2013 thru December 20, 2015	Active Physician
Kates, Gayle L., MD Reappointment Effective:	ACHN November 20, 2013 thru November 19, 2015	Active Physician
Lavani, Romeen M., MD Reappointment Effective:	Critical Care November 20, 2013 thru November 19, 2015	Voluntary Physician
Martinez, Jaime, MD Reappointment Effective:	Adolescent Medicine December 16, 2013 thru December 15, 2015	Active Physician

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John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Psychiatry

Tachauer, Alessandra MD	Psychiatry	Active Physician
Reappointment Effective:	November 20, 2013 thru November 19, 2015	

Department of Surgery

Patel, Urjeet A., MD	Surgery/Otolarynology	Active Physician
Reappointment Effective:	December 16, 2013 thru December 15, 2015	

Renewal of Privileges for Non-Medical Staff

Baldauff, Leah J., PA-C	Surgery / Orthopaedic	Physician Assistant
With Wysocki, Robert W., MD		
Alternate Szatkowski, Jan Paul, MD		
Effective:	November 20, 2013 thru November 19, 2015	
Clingerman, Stephen, PhD	Psychiatry	Clinical Psychologist
Effective:	December 16, 2013 thru December 15, 2015	
Holden, M. C., PA-C	Medicine / General Medicine	Physician Assistant
With Ganschow, Pamela S., MD		
Alternate Aluen Metzner, Irene S.A., MD		
With Marcus, Elizabeth A., MD	Surgery / Breast Oncology	
Alternate Lazzaro, Gianluca, MD		
Effective:	November 20, 2013 thru November 19, 2015	
Norcott, Candice, PhD	Family Medicine	Clinical Psychologist
Effective:	November 20, 2013 thru November 19, 2015	
Sickel, Sarah L., CRNA	Anesthesiology	Nurse Anesthetist
Effective:	December 16, 2013 thru December 15, 2015	
Trammell, Glen D., PA-C	Correctional Health Services	Physician Assistant
With Khan, Marghoob Ahmad, MD		
Alternate Ledvora, Ronald F., MD		
Effective:	December 16, 2013 thru December 15, 2015	
Uddin, Farhana F., PA-C	Surgery / Urology	Physician Assistant
With Wille, Mark A., MD		
Alternate Hollowell, Courtney M., MD		
Effective:	December 29, 2013 thru December 28, 2015	

Non-Medical Staff Change in Clinical Privileges

Bonilla, Amy L., PA-C	Medicine / Infectious Disease	Physician Assistant
With Kendrick, Sabrina R., MD		
Alternate Maric, Nevenka, MD		
Effective:	November 20, 2013 thru August 18, 2015	
Melvin, Amy M., CNP	Medicine / Pulmonary & Critical Care	Nurse Practitioner
With Muzaffar, Shirin, MD		
Effective:	November 20, 2013 thru August 20, 2014	

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Provident Hospital of Cook County

Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Rossi, Enrica, MD	Surgery/Ophthalmology	Voluntary Physician
Appointment Effective:	November 20, 2013 thru November 19, 2015	

REAPPOINTMENT APPLICATIONS

Renewal of Privileges for Non-Medical Staff

Baldauff, Leah J., PA-C	Surgery / Orthopaedic	Physician Assistant
With Szatkowski, Jan Paul, MD		
Alternate Crawford, Clifford S., MD		
Effective:	November 20, 2013 thru November 19, 2015	

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ON NOVEMBER 20, 2013

ATTACHMENT #3

Hospital Readmissions Reduction Program Overview and Key Issues

Quality and Patient Safety Committee

Cook County Health & Hospitals System Board

November 20, 2013

Hospital Readmissions Reduction Program
Background

• The Affordable Care Act amended the Social Security Act establishing the Hospital Readmissions Reduction Program.

• The Hospital Readmissions Reduction Program requires CMS to reduce payments to the inpatient prospective payment system (IPPS) to hospitals with excess readmissions.

• The Hospital Readmissions Reduction Program was effective for discharges beginning October 1, 2012.

Hospital Readmissions Reduction Program

Background

- The Centers for Medicare and Medicaid Services (CMS) uses 30-day readmissions measures for three conditions:
  - heart attack/acute myocardial infarction (AMI)
  - heart failure (HF)
  - pneumonia (PN)

- Hospitals with fewer than 25 discharges for each condition are excluded

- Hospitals with "excess" readmissions have their Medicare payments reduced by up to:
  - 1% in FY 2013
  - 2% in FY 2014
  - 3% in FY 2015 and beyond

Hospital Readmissions Reduction Program
Defining Readmission

- What counts as a readmission?

  The 30-day readmission measures all readmissions to any short-term acute care hospital within 30 days of discharge.

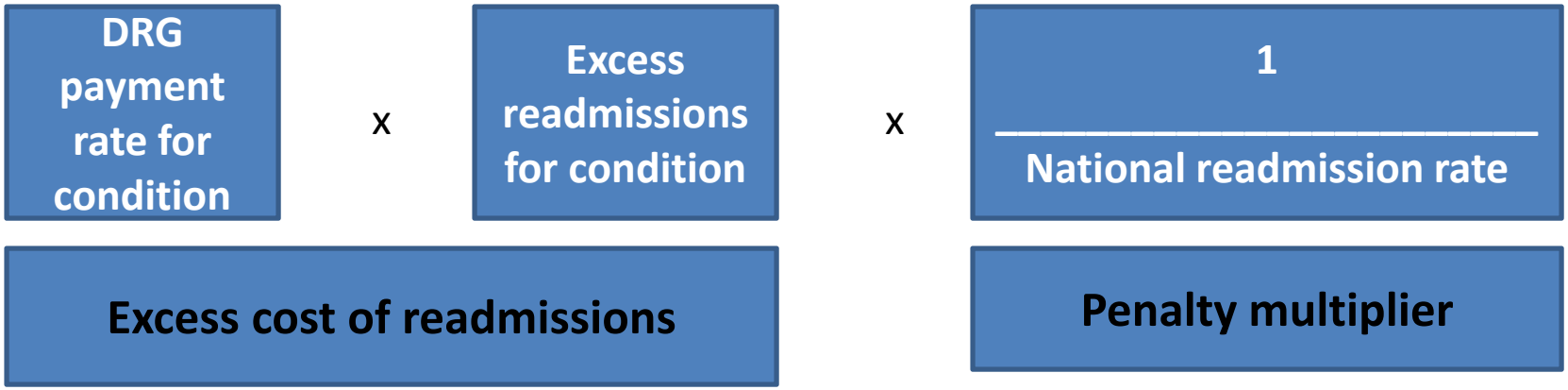
- Two exceptions:

  Planned readmission

  Same-day readmissions for the same condition to the same hospital

Hospital Readmissions Reduction Program

Payment Penalty Formula



- Magnitude of penalty is inversely related to national readmissions rate
  - So as national rates drop, penalties may actually increase

- Multiplier means penalty is disproportionate to actual cost of excess readmissions
  - E.g. given a national readmit rate of nearly 20%, penalty for AMI ~ 5x greater

Hospital Readmissions Reduction Program
Key Policy Issues

- **Payment penalty formula**

  Overstates costs of excess readmissions

- **Measures**

  No exclusion for readmissions unrelated to the reason for initial admission

  No adjustments for socioeconomic factors

Hospital Readmissions Reduction Program
Socioeconomic Adjustment

- Hospitals committed to reduce readmissions

  But readmissions are affected by a variety of factors, many of which are beyond hospital control

- Disparities exist in community resources available to help reduce readmissions (e.g.—home health agencies, primary care and pharmacies)

- Compelling evidence that hospitals treating disadvantaged patients and communities more likely to incur penalties

- **Adjusting for socioeconomic factors would acknowledge the reality that hospitals cannot always control or change structural issues**

Readmissions Data: Stroger Hospital

Condition	SHCC 2012	SHCC 2013	US Rate
Acute MI	19.8%	18.7%	18.3%
Heart Failure	25.5%	24.1%	23.0%
Pneumonia	18.7%	25.2%	17.6%
All Causes		23.3%	19.6%*

Readmissions Penalty for 2013 (YTD):
CCHHS: $66,798
Stroger: $62,441

***Data from: Jencks SF et al. N Engl J Med 2009;360:1418-1428.**

Readmission: Risk Factors

- Severity of illness or disability
- Socioeconomic disadvantage
- Previous readmission(s)
- Race
- Care at safety net hospitals
  - High admission rate from ED
  - Observation status for lower risk patients

Readmissions: Penalty by Hospital Type

Table. Hospital Characteristics by Penalty Group[a]

	High Penalties (n = 1097)[b]			Low Penalties (n = 1092)[c]			No Penalties, Unadjusted Rates, No. (%) (n = 1093)[d]
	Unadjusted Rates, No. (%)	Multivariate-Adjusted OR (95% CI)	*P* Value	Unadjusted Rates, No. (%)	Multivariate-Adjusted OR (95% CI)	*P* Value	
Size of hospital							
Large (≥ 400 beds)	178 (40)	1.98 (1.44-2.74)	<.001	158 (36)	2.07 (1.50-2.87)	<.001	108 (24)
Medium (200-399 beds)	622 (35)	2.09 (1.78-2.53)	<.001	659 (37)	2.43 (2.01-2.94)	<.001	482 (27)
Small (<200 beds)	296 (28)	1 [Reference]		275 (26)	1 [Reference]		503 (47)
Teaching hospital							
Major	118 (44)	1.56 (1.04-2.32)	.03	102 (38)	1.46 (0.98-2.19)	.07	50 (19)
Not major	979 (33)	1 [Reference]		990 (33)	1 [Reference]		1043 (35)
Safety-net hospital							
Yes	337 (44)	2.38 (1.91-2.96)	<.001	275 (36)	1.83 (1.46-2.29)	<.001	157 (20)
No	760 (30)	1 [Reference]		817 (33)	1 [Reference]		936 (37)

Abbreviation: OR, odds ratio.

[a] The unadjusted mean (SD) payment penalty for hospitals with high penalties is 0.72% (0.23%); low penalties, 0.15% (0.10%); and no penalties, 0. The unadjusted mean (SD) number of admissions for hospitals with high penalties is 945.7 (790.1); low penalties, 791.3 (654.5); and no penalties, 623.8 (743.6). The number of admissions includes the following types of diagnoses: acute myocardial infarction, congestive heart failure, and pneumonia, which are the 3 conditions assessed under the Hospital Readmissions Reduction Program.

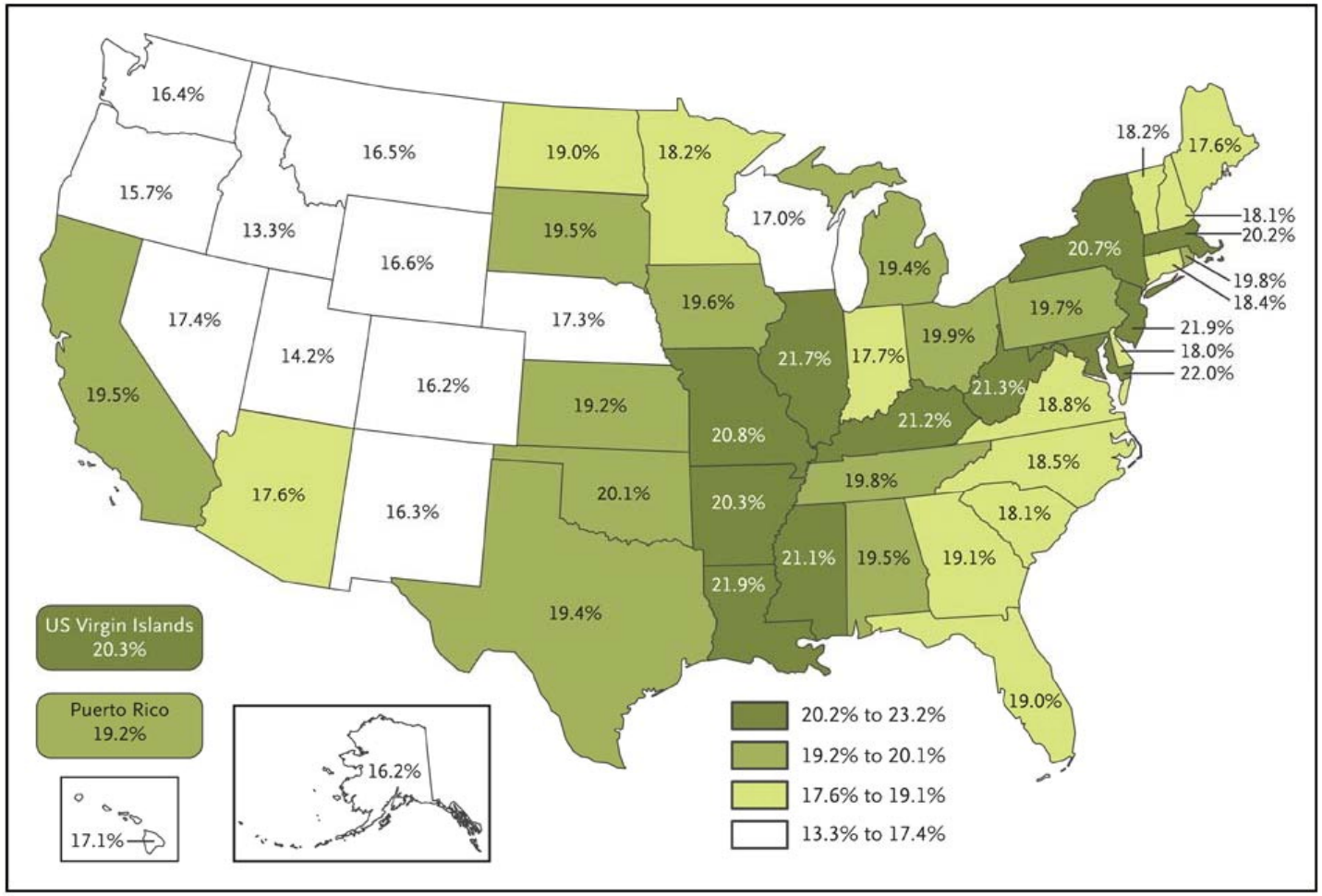
[b] Made up of hospitals that will receive above-average penalties under the Hospital Readmissions Reduction Program.

[c] Made up of hospitals that will receive below-average penalties.

[d] Made up of hospitals that will not be penalized.

Joynt and Jha. JAMA 2013;309:342-343.

Rates of Readmission: Hospitalization within 30 Days after Hospital Discharge



Jencks SF et al. N Engl J Med 2009;360:1418-1428.

Readmissions: Improving Care*
Project RED: An Improvement Paradigm

Eleven mutually reinforcing components:

1. Medication reconciliation
2. Reconcile discharge plan with national guidelines
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone reinforcement

***Project RED Checklist, AHRQ**